



JAMES T. MARTIN, JR., MD

PLEASE COMPLETE ALL SECTIONS

Patient Information

Dr. James T. Martin, Jr., M.D.

Rebecca Miller, PA-C

Martha Green, PA-C

Today's Date: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____ / _____ / _____

Title (Ms., Miss., Mrs., Dr.) _____

Last name: _____ First name: _____ Middle Initial: _____

What name do you preferred to be called? _____

Address: _____ Apt # _____

City: _____ State: _____ Zip code: _____ County: _____

Home phone: () _____ - _____ Cell phone: () _____ - _____ Email: _____

Mailing Address: (if different than above address)

_____ Apt # _____

City: _____ State: _____ Zip code: _____

Race: _____ Marital Status: (please circle one) Single - Married - Divorced - Separated - Widow

Student Status: (please circle one) None - Full Time - Part Time

Employment Status: (please circle one) Not Employed - Full Time - Part Time - Self Employed - Military - Active Duty - Retired

Employer Name: _____

Work Phone: () _____ - _____ Ext. _____ OK to Call? Yes _____ No _____

Spouse's Name: _____ SSN: _____ - _____ - _____ DOB: _____ / _____ / _____

Spouse's Employer: _____ Work Phone: () _____ - _____

Emergency Contact: _____ Phone: () _____ - _____

Referred by: _____ Phone: () _____ - _____

Primary Doctor: _____ Phone: () _____ - _____

Pharmacy: _____ Phone: () _____ - _____

PLEASE READ, READ, READ ALL THIS INFORMATION.

Note: Accurate insurance information is vital for your financial responsibility to this office and correct scheduling of subsequent test or procedures. If insurance information is incorrect, we will require collection of payment in full at the time of service(s); and subsequent scheduling of tests or procedures may be affected.
ALL INFORMATION HAS TO BE FILLED OUT BELOW

Primary Insurance Information: (If Other Is Circled, Complete Additional Information)

Insured Relationship to Patient: (please circle one) Self or Other _____

Insurance Name: _____

Name of Insured: _____

Secondary Insurance Information: (If Other Is Circled, Complete Additional Information)

Insured Relationship to Patient: (please circle one) Self or Other _____

Insurance Name: _____

Name of Insured: _____

Insurance Cards Available to Scan: Yes _____ No _____

ALL INFORMATION HAS TO BE FILLED OUT BELOW

The primary insured person's name: _____

The home address of insured person: _____

The home phone number of insured person: () _____ / _____ Work number of insured person: () _____ / _____

Cell phone number: () _____ / _____ The SS# _____ - _____ - _____ DOB: _____ / _____ / _____

The secondary insured person's name: _____

The home address of insured person: _____

The home phone number of insured person: () _____ / _____ Work number of insured person: () _____ / _____

Cell phone number () _____ / _____ SS# _____ - _____ - _____ DOB: _____ / _____ / _____

Who is the person this office needs to bill: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT: (PLEASE READ ALL THIS INFORMATION)

I do hereby authorize D. James T. Martin, Jr., M.D. and/or staff to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am to immediately notify Dr. James T. Martin's office if any changes occur in my insurance. Payment is expected at time/date of service.

All professional services rendered are charged to the patient. There will be a charge of \$10.00 for NSF checks if turned over to a collection agency. If not turned over to a collection agency, you will be charged \$35.00 for an NSF check.

If surgery or in-office surgical procedures are indicated, the patient is responsible for furnishing insurance claims to the office prior to surgery and the patient is responsible for paying in-advance in full before any procedure is done. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. If this account has to be turned over to collection, the undersigned grantor (parent or guardian, if patient is a minor or going to college and of age) agrees to pay all legally allowed interest and all collection and attorney's fees. There is a \$10.00 per form fee for disability, worker-compensation, FMLA forms etc. Obtaining/copying of medical records requires a \$15.00 administration fee, 0.65 per page charge after the 15th page and postage will be expected when records are released. Dr. James Martin's office requests a 24 hour cancellation notice of a scheduled appointment. After the 3rd no show appointment without prior cancellation, there may be a \$25.00 no show fee added to the patient's account. Rates/fees subject to change without notice.

I understand that insurance is filed as a courtesy and that any charges not covered by my insurance will be the responsibility of the above-designated person.

I further understand that I will be responsible for any collection and/or legal fees and monthly interest accrued due to non-payment. Accrued interest rate = 18% per year.

Patient's Signature: _____ Date: _____

If patient under the age of 18, person financially responsible signature: _____ Date: _____

Relationship: _____